Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GARLAND COMMUNITY HOSPITAL
C/O LAW OFFICE OF P MATTHEW ONEILL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729

Respondent Name

ST PAUL FIRE & MARINE INSURANCE

Carrier's Austin Representative Box

Box Number 5

MFDR Tracking Number

M4-98-D186-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "St. Paul Ins. Paid only 7 days, not the full 9 days. Please direct St. Paul Ins. To remit payment for the additional 2 days, which were medically necessary."

Amount in Dispute: $29,144.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The dates of service at issue do not fall under the provisions of the 1992 Acute Care Inpatient Hospital Fee Guideline. The applicable guideline is the 1997 guideline Acute Care Inpatient Hospital Fee Guideline. There has been no adjudication that the 1997 guideline is not fair or reasonable; therefore, the request for further reimbursement is not appropriate."

Response Submitted by: St. Paul fire & Marine Ins. Co., Flahive, Ogden & Latson 505 West 12th Street Austin TX

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 11, 1997 through August 20, 1997	Inpatient Hospital Services	$29,144.06	$2,678.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out

the reimbursement guidelines for the services in dispute.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on July 17, 1998.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F Payment based on the assigned Per Diem amount per the 1997 Texas Inpatient Hospital Fee Guideline.
   - M The amount paid is equal to or exceeds the payment required under Texas Workers' compensation Act (TWCA) statutory standard for payment of medical providers.
   - G Payment for these services is included in the Per Diem amount.

Findings

1. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guidelin*e at 28 Texas Administrative Code §134.400, 17 *TexReg* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."
2. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
3. Although the 1997 Acute Care Inpatient Hospital Fee Guideline was not in effect on the dates of service in dispute, the insurance carrier has adopted as its fair and reasonable methodology for reimbursement the methodology as promulgated in Texas Administrative Code §134.401, adopted to be effective August 1, 1997, 22TexReg 6264. The requestor does not dispute the carrier's selected fair and reasonable reimbursement methodology.
4. In dispute, however, is the number of days to be reimbursed under the insurance carrier's chosen methodology. The requestor's position statement asserts that "St. Paul Ins. Paid only 7 days, not the full 9 days. Please direct St. Paul Ins. To remit payment for the additional 2 days, which were medically necessary."
5. No documentation was submitted by either party to support that services were reduced or denied for unnecessary medical treatment. Former Texas Labor Code §408.027(d)[currently 408.027(e)], Acts 1993 73rd Legislature, chapter 269, effective September 1, 1993, requires that "If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the commission [now the Division], the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee. "The insurance carrier did not indicate any Division specified explanation codes involving medical necessity on the explanation of benefits. The explanation of benefits does contain an auditor comment that "PER PEER REVIEW: 7 DAYS LOS [length of stay] APPROPRIATE. IMPLANTS RECOMMENDED @ COST + 10%." However, although the carrier indicates that per peer review it found a 7 day length of stay to be appropriate, the auditor's comment is silent as to the reason for denial of the remaining 2 days. No copy of the referenced peer review was submitted for consideration in this dispute. No documentation was found to support that the insurance carrier sent to the commission[now the Division], the health care provider, and the injured employee the required report regarding medical necessity or containing sufficient explanation of the above reason(s) for the reduction or denial of payment of the remaining 2 days treatment. Therefore, the Division concludes that medical necessity is not in dispute. The disputed services will therefore be reviewed per applicable Division rules pursuant to the fair and reasonable reimbursement methodology proposed by the respondent.

6. The respondent adopted as its fair and reasonable reimbursement methodology the per diem reimbursement calculation "per the 1997 Texas Inpatient Hospital Fee Guideline" as promulgated in Texas Administrative Code §134.401, adopted to be effective August 1, 1997, 22 TexReg 6264. Under §134.401(c) (1) " The workers' compensation standard per diem amounts to be used in calculating the reimbursement to acute care inpatient services are as follows: Medical --$870; Surgical --$1118; Intensive Care Unit(ICU)/Cardiac Care Unit--$1,560." Review of the submitted medical bill finds that the provider billed 8 days surgical care and 1 day treatment in the intensive care unit. According to §134.401(c) (3)(A)(ii-iii), "the applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…If applicable, ICU/CCU days are subtracted from the total LOS and reimbursed the ICU/CCU per diem rate for those specific days of treatment in lieu of the assigned medical/surgical per diem rate." The Division finds that the total length of stay is 9 days, 8 days of which shall be reimbursed according to the surgical per diem of $1,118, and 1 day of which shall be reimbursed according to the ICU per diem of $1,560. Reimbursement is calculated as follows: 8 days x $1,118 (surgical per diem) = $8,944 + $1,560(ICU per diem) = $10, 504. In addition, the carrier paid revenue code 278 for billed implantables/supplies at cost plus10% in the amount of $11, 376.95 (which is not disputed by the requestor for a total reimbursement amount of $21, 880.95. The Division concludes that the total payment amount calculated according to the fair and reasonable reimbursement methodology proposed by the respondent is $21, 880.95. This amount less the amount previously paid by the insurance carrier of $19, 202.95, leaves an amount due to the requestor of $2, 678.00. This amount is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports that additional reimbursement is due. As a result, the amount ordered is $2,678.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031and §413.019 (if applicable), the Division has determined that the requestor is entitled to $2,678.00. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,678.00 plus applicable accrued interest per 28 Texas administrative Code §134.803, and /or §134.130 if applicable, due within 30 days of receipt of this Order, the Division has determined that the requestor is entitled to $2,678.00 reimbursement for the disputed services.

Authorized Signature

		August 14, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		August 14, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.